THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 18, 2011

Julius Genachowski, Chairman
Federal Communications Commission
445 12th Street, SW
8-B201
Washington, DC 20554

Dear Chairman Genachowski:

Through the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act of 2009, Congress authorized an unprecedented investment in health IT. Specifically, the HITECH Act authorized the Department of Health and Human Services (HHS) to establish programs to improve health care quality, safety, and efficiency through the promotion of certified health IT, including certified electronic health records and private and secure electronic health information exchange. Accordingly, HHS will provide meaningful use incentive payments (estimated at $20 to $27 billion) to eligible health care providers when they adopt and use certified electronic health record technology in a meaningful way. For example, when doctors use certified electronic health record technology to prescribe medication electronically or to track and report clinical quality measures (e.g., children's height and weight, blood pressure), they are using the technology in a meaningful way. Additionally, Congress charged the HHS Office of the National Coordinator for Health IT (ONC) with coordinating the federal government's efforts to realize the implementation of a nationwide health IT infrastructure within a legislatively mandated timeline.

There is urgency to increase broadband access to rural health care providers. By statute, HHS meaningful use incentive payments will only be available for a limited time. Beginning in 2015, Medicare will pay health care providers less if they do not meaningfully use certified electronic health record technology. Without targeted support over the next two years, this could have a great impact on rural America because of the large Medicare population that rural health care providers typically serve.

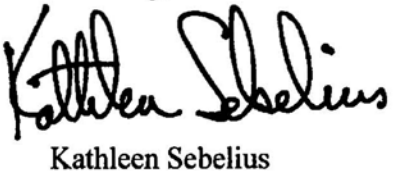
In February 2010, the White House created a task force to coordinate efforts and investments to meet this health IT agenda. Access to a sufficient level of broadband services that enables the transmission of relevant patient data in a secure and reliable way is a key element of the Administration's larger efforts to ensure that, ultimately, all health care providers become meaningful users of health IT and that all Americans benefit from access to certified electronic health record technology.

Mr. Chairman, in August, 2010, I met with you, the Secretaries of Agriculture and Commerce, as well as a Veterans Affairs representative to discuss inter-agency collaborations to ensure

widespread adoption of health IT. As a result of this meeting, HHS has sought to collaborate with FCC and provide comments on its proposed rules, including the comments to the Connect America Fund (enclosed in this letter) and our 2010 comments to the Rural Health Care Support Mechanism. HHS's objective in commenting on these proposed rules is to support FCC's efforts to address serious broadband capacity and connection issues facing communities across America, especially rural health care providers and the patients they serve. We encourage FCC to consider our comments in light of the aggressive timelines Congress has placed on eligible health care providers to achieve meaningful use of certified electronic health record technology, which is dependent on access to broadband services. We hope that FCC will act quickly to improve rural health care providers' access to broadband connectivity in time for these providers to adopt certified electronic health record technology and achieve meaningful use – a milestone that takes time, and in many cases years, for providers to reach – before they incur penalties. Further, addressing our comments and supporting widespread adoption of health IT is an effective way for FCC to address barriers to broadband adoption and utilization among, for example, older and minority Americans. That is, for each healthcare provider that adopts health care models that are based on health IT, many more patients will, in turn, be encouraged to adopt and use broadband at home.

Thank you for the opportunity to provide these comments. We greatly look forward to continuing to collaborate with FCC on reforming its programs to ensure that the Federal Government supports health IT needs regardless of the location of patients and health care providers.

Sincerely,



Kathleen Sebelius

Enclosure

General HHS Comments

The Department of Health and Human Services (HHS) appreciates the opportunity to provide comments on the Federal Communications Commission's (FCC) proposed rule on the Connect America Fund (CAF) that will accelerate broadband investment in unserved areas across America. In doing so, HHS also appreciates the opportunity to comment on proposed synergies across the Universal Service Fund programs, especially between the Rural Health Care Support Mechanism and CAF. HHS's objective in providing these comments is to ensure that the result of FCC's reform activities can support the health information technology (health IT) needs of health care providers and the patients they serve, especially those in rural communities.

Congress's and the Administration's goal is to improve the quality of care for all Americans through a transition away from a paper and pencil health care system to the widespread adoption and meaningful use of health IT. This includes the use of electronic health records (EHR) instead of paper medical records to maintain patient health information and exchange it among doctors and hospitals and their patients. Health IT can, among other things, help health care providers detect health concerns earlier, lower the cost of care, reach patients in very remote areas of the country using telemedicine, coordinate care, and avoid medical errors. With access to health IT, patients can also be empowered to manage their personal health care. Broadband connectivity enables the exchange of electronic health information and the development and implementation of innovative health care models that support remote access to health care and the electronic exchange of health care data.

We encourage FCC to ensure that its programs support the specific needs of the health care system, which can be different from the needs of school and library systems. In reforming its programs, FCC should take into account that broadband connectivity must be sufficient to reliably transmit relevant patient data. Redundancy and reliability of telecommunication infrastructure is paramount to ensuring that the health care system serves all American communities, including rural communities. Ultimately, both patients and providers should be able to access and exchange health information electronically. Therefore, FCC's programs should support broadband needs of the different types of health care providers and the patients they serve. In determining the sufficiency of the broadband connectivity, FCC should take into account that different users have different broadband needs. For example, patients in their homes require less demanding capabilities than clinics with several clinicians. In addition, large hospitals require significantly more broadband support (e.g., dedicated internet access) than small clinics with a single clinician.

Improving patient access to broadband and mobile connectivity enables patients to manage their own care more effectively while away from the doctor's office by accessing health care services and their medical records remotely. For example, patients with chronic conditions can benefit from remote monitoring technology and access to health information through secure messaging (e.g., secure email) without leaving their homes. In addition, improving health care provider access to broadband connectivity enables these providers to adopt tools that support clinicians' management of patient health care. Remote consultations allow patients to receive care where they have the support of their primary health care team and family or friends, reduce transportation costs, and improve the overall quality of care. Telehealth capabilities can be especially beneficial in rural areas that have limited access to specialists. For instance, most rural

communities are unable to recruit and retain a sufficient number of psychiatrists. Primary care teams serving patients and families with mental health needs in rural areas can benefit tremendously from telepsychiatry, which has been proven to provide accurate and reliable service in a variety of settings.

Further, FCC should ensure that the programs it is designing are flexible enough to adapt to future changes and innovations in the health care industry. As the health care system continues to launch health information exchanges (within which health care providers exchange patient health information electronically), adopt health care models based on the electronic exchange of health information (e.g., large images and genetic files), rely on videoconferencing capabilities, and so on, the demand for broadband infrastructure and services will continue to increase and evolve. For example, Mayo Clinic and other large institutions are members of a network that utilizes a robust broadband infrastructure to transmit large health data files (e.g., patient records). In the future, America's broadband infrastructure should support a health care system where such a system of electronic exchange of information replaces physical transfer of data on disks. FCC's programs should plan to support the next generation of networks that will require synchronous, vigorous data exchange that can maintain data that is liquid (i.e., easy to access and process).

From the patient's perspective, FCC should support an infrastructure that, in the future, will afford increased telecommunications capabilities outside of the doctor's office. The next generation infrastructure may enable patients across the U.S. to, among other things, access their personal health records from home using web-based platforms that require high speed internet. In addition, broadband capacity may allow patients to manage scheduling, billing, and follow-up care online rather than by phone or in the doctor's office.

Finally, in considering whether to consolidate existing programs and assessing the extent to which CAF can meet America's rural health IT needs, FCC should take into account that CAF is oriented to the individual consumer. In contrast, the Rural Health Care Support Mechanism is designed to cover the needs of larger health care provider organizations. In order to fill rural health IT needs, we strongly encourage that FCC design its programs to enable health care providers to secure adequate broadband connectivity, including large hospitals that often require dedicated internet access where individual patients' homes may only need mass market options. Additionally, as FCC expands broadband infrastructure, it should consider that the needs of hospitals are different from, and potentially more demanding than, schools and libraries.

Specific HHS Comments

Paragraphs 291 and 295

Defining Unserved: We recommend that FCC consider communities that do not have access to reliable, sufficient and affordable broadband to be "unserved" communities for the purposes of CAF, because these communities cannot benefit from health IT enabled health care models without such connectivity.

A community that does not have reliable connectivity should be considered unserved because health care providers in those areas will not be able to transition to health care models that rely on the electronic exchange of health information. For example, in rural communities with no or few local mental health care providers (e.g., psychiatrists), primary care teams working in these

communities may not be inclined to incorporate behavioral and mental health into their clinical models where such care would otherwise be beneficial, if videoconferencing sessions with psychiatrists were hindered by intermittent or more-than-occasional lapses in connectivity. Consequently, these rural communities would be unserved because they would not benefit from new clinical and business models that incorporate telepsychiatry because of unreliable telecommunications services.

A community where patients and/or hospitals do not have access to sufficient broadband connectivity to support innovative health care models will be unable to benefit from health IT (i.e., unserved). In certain circumstances, a rural hospital may be considered unserved if it needs dedicated internet access in order to adopt successful clinical models supported by health IT, but is unable to implement these new models because it has limited connectivity (e.g., dial-up). We are aware of rural areas without connectivity sufficient to support videoconferencing. Therefore, many rural areas would be unserved because they do not have access to real time specialty consultative services. For example, the Mississippi Delta, an 18 county region, suffers from a high level of diabetes and a shortage of specialists, including endocrinologists. In this region, providers practice in small settings located far from each other and from regional hospitals. High-speed broadband access has been limited, especially for physician practices and hospitals. Without sufficient broadband to support high definition video conferencing and the transmission of electronic health record data, patients in this region would have limited interactions with endocrinologists. Residential internet capabilities are reaching the area, but patients are unable to access sufficient broadband to transmit and receive medical data securely, which would empower them to manage the care of their own chronic disease. Providing patients with access to sufficient broadband has important implications for controlling patients' health care costs. That is, if these are patients are not able to control their diabetes, they could have significantly higher costs overall.

A second example would be Hawaii, also largely a rural community, where Hawaiians outside of the capital city struggle because they rely on physicians in Honolulu to provide vital services. Without broadband access on the islands and wireless capabilities across the islands, Hawaiians are often limited in their access to quality primary and specialist care close to their homes.

Communities where patients and/or hospitals cannot afford access to sufficient, reliable broadband should be considered unserved, regardless of their location. Patients discharged after hospital admissions for heart failure have improved health outcomes if they can manage their care from home through remote monitoring care models. Without access to affordable broadband service, patients will not be able to participate in such programs, making them more likely to be readmitted to the hospital for those chronic conditions. In addition, there are Federal Indian Health Service, tribal, and urban Indian clinics (some of which are located in urban areas) that often cannot afford access to sufficient reliable broadband. Without access to these telecommunications services, they cannot improve their health care models.

We recommend that FCC define rural communities as "unserved areas" and ensure that its programs support the needs of these communities.[1] In identifying rural communities that require

[1] For all the HHS Health Resources and Services Administration's rural health grants, all counties that are not part of a Metropolitan Statistical Area are considered rural. The White House's Office of Management and Budget (OMB) designates counties as either Metropolitan, Micropolitan, or Neither. Micropolitan counties are considered

support, FCC should be aware that Census blocks may not provide a sufficient degree of granularity. HHS recommends using the Rural-Urban commuting area (RUCA) codes to identify rural communities. These codes are based on Census data, but provide greater granularity.[2] For example, San Bernardino County, California is a very large county with a population of over 1.7 million. The Census block identifies the entire area as urban. However, most of the population is concentrated in a small area of the county, while other areas have a very low population density of as low as 10 people per square mile. The RUCA code enables HHS to correctly identify the rest of the county as rural, including an area that has a density of 10 people per square mile.

Defining Sufficient Levels of Connectivity: FCC published information on broadband capacity necessary to support various use cases in health care, from single health care providers to larger hospitals.[3] While we support these figures, we encourage FCC to design its programs around an understanding that capabilities and technologies will evolve in the future. FCC's programs should support the capabilities the Federal Government would like to afford the U.S. health care system now, as well as the innovations we would like to see widely adopted in the future. Therefore, FCC's programs should be flexible with respect to the exact amount of bandwidth required for each use case; as capacities and technologies evolve, the exact bandwidth required will change.

In considering how much broadband capacity is necessary to support the health IT needs of individual patients outside of the doctor's office, we recommend that FCC look to the needs of small health care providers with one clinician. Specifically, we recommend that FCC's programs provide similar support to both individual consumers and providers with one clinician.

Paragraphs 295 and 408

Identifying Unserved Units: FCC's programs should address the needs of health care providers in accordance with the following definition of "health care provider" Congress used in 2009 in the HITECH Act:

> "The term 'health care provider' includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, health care clinic, community mental health center (as defined in section 1913(b)(1)), renal dialysis facility, blood center, ambulatory surgical center described in section 1833(i) of the Social Security Act, emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as described in section 1842(b)(18)(C) of the Social Security Act), a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act), tribal organization, or urban Indian organization (as defined in section 4 of the

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non-Metropolitan or rural. For more information on Metro areas, see: http://www.census.gov/population/www/estimates/metroarea.html

[2] For more information on RUCAs, see: http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/

[3] See exhibit C of the white paper support bb requirements associated with these use cases: 2010 Healthcare Broadband in America working paper: http://download.broadband.gov/plan/fcc-omnibus-broadband-initiative-(obi)-working-reports-series-technical-paper-health-care-broadband-in-america.pdf.

Indian Health Care Improvement Act), a rural health clinic, a covered entity under section 340B, an ambulatory surgical center described in section 1833(i) of the Social Security Act, a therapist (as defined in section 1848(k)(3)(B)(iii) of the Social Security Act), and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the Secretary."[4]

Considering the Effect of Funding a Single Telecommunications Provider: FCC should be cautious in considering whether its programs should support a single telecommunications provider in an area. A single carrier may not be able to meet the needs of different health care providers, such as larger hospitals that require dedicated internet access. In addition, for the purposes of rural health care especially, a single carrier may not afford the region sufficient redundancy and may leave the entire community vulnerable to total lapses in connectivity due to weather extremes and geographic conditions.

Moreover, certain clinics (e.g., Federal clinics) have contractual requirements that could prohibit them from benefitting from FCC's programs if FCC only supports a single telecommunications carrier per region. For example, HHS is contractually compelled to purchase data circuits from a specific vendor. If FCC selects a different vendor for an area, Indian Health Service facilities, for example, that region may not be able to benefit from the savings afforded by FCC's programs.

Paragraphs 149, 395, and 416

FCC programs intended to support the health care industry should ensure that connections supporting health care providers run directly into the health care facility with an appropriate level of throughput and reliability to support its health IT needs.

While there are benefits to utilizing a single infrastructure program (i.e., CAF) to support health IT needs for the unserved in America, FCC should take into account that CAF is targeted to individual consumers. For a single infrastructure to meet the needs covered by a purpose-specific program, such as the Rural Health Care Support Mechanism, it must address health IT needs of rural communities (e.g., infrastructure to support dedicated internet access for large health care institutions). FCC programs must also ensure that connectivity is affordable for health care providers and their patients. As such, FCC's investment should support the development of the telecommunications infrastructure, incentivize telecommunications providers to drive down cost, as well as subsidize the payment for telecommunications service fees, especially in rural communities.

As FCC expands broadband infrastructure, it should consider that the needs of the health care system are different from school and library systems. A hospital may need higher throughput and reliability to support the exchange of vital patient health information than is required by a small school that needs bandwidth sufficient to support email exchange and periodic internet searches. HHS supports expanded infrastructure as long as it does not compromise the quality of the care delivered. Specifically, health care facilities must have access to sufficient, reliable, and affordable broadband connectivity.

[4] In providing support to community mental health centers, also known as community behavioral health centers, FCC should note that HHS considers this term to also refer to centers that care for substance abuse patients.